

Office of Health Care Assurance

State Licensing Section

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name:</b> Bumanglag, Violeta (ARCH)	<b>CHAPTER 100.1</b>
<b>Address:</b> 2152 North School Street, Honolulu, Hawaii 96819	<b>Inspection Date:</b> April 23, 2019 Annual

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

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	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a) Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><b><u>FINDINGS</u></b> Resident #1, no evidence of the level of care (LOC) upon admission (5/1/18). ARCH LOC (5/7/18) after admission.</p>	<p><b>PART 1</b></p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-10 <u>Admission policies.</u> (a)  Type I ARCHs shall admit residents requiring care as stated in section 11-100.1-2. The level of care needed by the resident shall be determined and documented by that resident's physician or APRN prior to admission. Information as to each resident's level of care shall be obtained prior to a resident's admission to a Type I ARCH and shall be made available for review by the department, the resident, the resident's legal guardian, the resident's responsible placement agency, and others authorized by the resident to review it.</p> <p><b><u>FINDINGS</u></b>  Resident #1, no evidence of the level of care (LOC) upon admission (5/1/18). ARCH LOC (5/7/18) after admission.</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>I will obtain a level of care of the resident from the Dr. or APRN prior to admission to Adult Res. Care Home.</i></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b> Resident #1, no evidence of orders for three (3) medications received and made available upon admission (5/1/18):</p> <ul style="list-style-type: none"> <li>• “Omeprazole DR 20 mg i po QHS” made available; however order dated 5/7/18</li> <li>• “Ferrous Sulfate 325 mg i po QD” made available; however order dated 5/7/18</li> <li>• “Multivitamin i po QD” made available; however order dated 5/7/18</li> </ul>	<p><b>PART 1</b></p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications</u>. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN.</p> <p><b><u>FINDINGS</u></b> Resident #1, no clarification for order dated 5/7/18:</p> <ul style="list-style-type: none"> <li>“Lithium Carbonate 300 mg i cap po BID” ordered; however, licensee reports medication discontinued. No evidence of <u>verbal order to discontinue</u></li> </ul>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>clarified w/ the APRN re: D/C of Lithium Carbonate when the resident went for annual P.E. on 4/29/19. List of current meds also updated, clarified and corrected by APRN - According to APRN, this med has been discontinued.</i></p>	<p><i>4/29/19</i></p>

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STATE OF CONNECTICUT  
DEPARTMENT OF  
REGISTRATION  
STATE LICENSES DIV.

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (1) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><u>FINDINGS</u> Expired medication, no acceptable procedure for disposal. For example, four (4) expired creams with pharmacy labels segregated in a plastic bag and stored in the first aid kit.</p>	<p align="center"><b>PART 1</b></p> <p align="center"><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p align="center"><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>Removed the expired creams of the resident in the first aid kit - Placed in sealed plastic bag and disposed in hard container. (emptied liquid detergent container) Properly secured and discarded in the household bin (Black)</i></p>	<p><i>4/23/19</i></p> <p align="right">19 MAY -6 AM 43</p>



	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (l) There shall be an acceptable procedure to separately secure medication or dispose of discontinued medications.</p> <p><u>FINDINGS</u> Expired medication, no acceptable procedure for disposal. For example, four (4) expired creams with pharmacy labels segregated in a plastic bag and stored in the first aid kit.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I will not store any meds or creams in the first aid kit. All meds are stored in the designated med cabinet that is locked at all times. I will not mix meds with the first aid kit. Expired creams will be place in sealed Plastic bag and disposed in hard container (Emptied liquid Laundry detergent container) Properly secured and discard in the household container bin.</i></p>	<p>19 MAY -6 AM 4:3</p> <p>STATE OF NEW YORK DEPARTMENT OF SOCIETY SERVICES</p>

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(3) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of date of referral and admission, referral agency with address and telephone number, place or source from which admitted, physician, APRN, dentist, ophthalmologist, optometrist, psychiatrist, and all other medical or social service professionals who are currently treating the resident, next of kin, legal guardian, surrogate or other legally responsible agency;</p> <p><b><u>FINDINGS</u></b> Resident #1, resident emergency information form missing information. For example, form did not list new medication ordered on 3/27/19, diet order or tuberculosis clearance.</p>	<p><b>PART 1</b></p> <p><b><u>DID YOU CORRECT THE DEFICIENCY?</u></b></p> <p><b>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</b></p> <p><i>New med ordered 3/27/19 - Added and wrote down in the emergency information form. Wrote down also the diet order &amp; TB clearance in <del>the</del> emergency form of the resident.</i></p>	<p>4/23/19</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-23 <u>Physical environment.</u> (g)(3)(I)(i) Fire prevention protection.</p> <p>Type I ARCHs shall be in compliance with, but not limited to, the following provisions:</p> <p>Each resident of a Type I home must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions, except that a maximum of two residents, not so certified, may reside in the Type I home provided that either:</p> <p>For each such non-certified resident there must be a responsible adult on the premises of the home at all times that the non-certified resident is present in the home, and there must never be a stairway which must be negotiated for emergency exit by such non-certified resident;</p> <p><b>FINDINGS</b> Resident #1, self-preservation certificate signed on 5/7/18 after transfer from a licensed ARCH for admission 5/1/18.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

STATE OF VERMONT  
DEPARTMENT OF  
HEALTH CARE  
STATE LICENSING  
MAY -6 2018 11:43

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Licensee's/Administrator's Signature: Violeta Bumanglag

Print Name: VIOLETA BUMANGLAG

Date: 5-4-2019

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STATE OF HAWAII  
BENJAMIN A.  
STATE LICENSING